King County

Department of
Community and Human Services

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FINAL PROCUREMENT PLAN
Veterans and Human Services Levy: 2.1(a-1) & 5.7
2.1(a-1): Development of a triaged list of the homeless high utilizers of sobering, courts, jails and the health system
5.7: Consultation and training related to protocols and policies for release of information and sharing of patient information

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1. Goals (Overarching Investment Strategies)

The Veterans and Human Services Levy Service Improvement Plan (SIP) set a goal of ending homelessness through outreach, prevention, permanent supportive housing and employment (page 18-21 of the SIP) and increasing the effectiveness of resource management and evaluation (page 27 of the SIP).

2. Objective (Specific Investment Strategy)

#2.1: Partner in initiatives to identify, engage and house long-term homeless people who make the highest use of public safety and emergency medical systems (page 19 of the SIP).

- This procurement plan is the second of three that address this objective. The first, a procurement plan to enhance outreach and engagement of homeless people in South King County was approved in 2007 (SIP 2.1(b)).
- This second procurement plan focuses on the development of a county-wide database that will identify 'high utilizers.' This database will ultimately facilitate coordinated entry into existing and new housing, services and supports.
- A third procurement plan will propose specific strategies for the development of that coordinated outreach, engagement and entry system.

#5.7: Consultation and training related to protocols and policies for release of information and sharing of patient information (page 28 of the SIP).

- This procurement plan incorporates this related strategy to provide additional support and expertise for MHCADS and system partners during the development of the high utilizer database and coordinated entry system.

3. Population focus

Once fully implemented these specific strategies will address the unmet needs of adults who are chronically homeless or at risk of homelessness, who experience mental illness and/or substance abuse, and who are frequent users of emergency services, hospitals, jails, shelters,

sobering and/or detox centers. A proportion of these individuals will also be veterans of the United States military.

4. Need or Risk Information

Our public services, hospital emergency departments, jails and psychiatric hospitals are inundated with individuals in crisis. Many are frequent users who have complex and chronic needs that cannot be met effectively or efficiently in these high-cost settings. Frequent users are often involved in several systems of care (primary and behavioral health, social services, criminal justice, and housing systems).

Repeated visits to jails, emergency rooms, and hospitals are both costly and avoidable. These costs are often absorbed by public systems and therefore by the taxpayer. Incarceration often begins a vicious cycle of loss of housing and benefits, separation from treatment, and a criminal history that disqualifies individuals for future housing.

It is imperative that involved systems develop a coordinated, integrated, regional response to better meet the needs of these individuals. Currently, some collaborative teams and data sharing agreements facilitate information exchange and referrals to an increasing number of housing and supportive programs funded by federal, state and local sources. However, the county lacks a centralized, coordinated means to systematically identify and refer individuals to appropriate resources. With the assistance of the Levy funds, DCHS and local partners will be able to implement a shared information and referral system that will meet all federal, state and local confidentiality and privacy regulations and promote collaborative care coordination.

Local and national data excerpted from the Prevalence Profile (SIP #5.3) is highlighted below and demonstrates the powerful correlations between mental illness, substance abuse and arrests, jail use, emergency room use, hospitalization (both medical and psychiatric) and homelessness.

Users of emergency services

- The 600 highest users of Harborview Medical Center's Emergency Department (ED) in 2005 accounted for ten percent of all emergency cases with almost 8000 emergency 'admissions'**.** Over a third of these high users were homeless. While approximately 10 percent had a primary diagnosis of mental illness or substance use, many more had these issues secondary to the primary medical concerns that prompted them to seek care.
- Half of all those served in 2006 by Harborview's specialty psychiatric emergency department had co-occurring mental illness and substance abuse problems; a third were homeless.
- In recent years, other hospital emergency departments in King County have experienced increased numbers of persons with mental illness and chemical dependency problems. Although precise data is not available, one indicator of the magnitude of the problem is the persistent 'boarding' of involuntarily detained mentally ill individuals in emergency rooms due to a lack of psychiatric inpatient beds. Approximately 30-40 individuals per month spend several days in emergency rooms and medical units waiting for a psychiatric bed.

- A 2004 national study of community hospital utilization by persons with mental health and/or substance abuse disorders indicated that adults with these problems accounted for a quarter of all hospital stays. Over two-thirds of these admissions were billed to government insurers (e.g., Medicaid/Medicare). Well over half were admitted after entering through emergency departments.
- The vast majority of people admitted to the King County Sobering Center and Detox services in both 2005 and 2006 were homeless.

Homeless persons

- The incidence of recent incarceration among homeless adults receiving mental health treatment is 4 times the incidence of those who have housing.
- The incidence of homelessness in adults with co-occurring disorders receiving mental health treatment is 3 to 4 times the incidence of those without co-occurring disorders.
- The 2006 "One Night Count" indicated that almost a quarter of homeless individuals for whom this information was available had problems with mental illness or substance abuse. [The 2007 "One Night Count" indicated a slightly lower percentage, but results from these 'snapshots' are believed to be a significant under-representation of overall need.]
- Almost a third of the people served by King County's Health Care for the Homeless (HCH) in 2006 had mental health and/or substance abuse problems. Nearly half had no health insurance. HCH estimates that they reach only a third of the homeless population.

Users of the justice system

- Approximately five percent (~1,500) of adults released from King County jails in 2006 had some indication of serious mental illness. This five percent comprised two thirds of the jails' highest users, and:
    - Almost a fifth had some indication of substance abuse.
    - Estimates suggest that half were homeless prior to entering jail.

- A six-year study conducted by University of North Carolina (UNC) researchers revealed that of the 20,200 King County individuals with serious mental illness receiving publicly funded mental health care:
    - 7,000 were jailed at least once;
    - Two-thirds were detained for 'minor' crimes (misdemeanors and non-violent felonies); a third was detained for violent felonies.
    - Those committing minor crimes were predominately Caucasian males (73 percent); a quarter of them were African Americans.
    - Those committing felonies were predominately Caucasian males (64 percent); a third of them were African Americans.

- According to the UNC researchers, of the chronic, most severely and persistently mentally ill clients (~7,200) receiving mental health care in King County during that six year study, almost half had a co-occurring substance abuse disorder.
    - One-fifth was homeless at some point.

- Of the 940 that were homeless and had co-occurring disorders, three quarters of these were users of psychiatric hospitals (with an average stay of 30 days) and had been jailed at least once (with an average of six bookings).

- On any given day in city jails throughout King County, an estimated 15 percent of inmates have serious mental illness, 80 percent have substance abuse problems, and five percent have co-occurring disorders (average daily census ~ 400).

- When jailed, individuals with mental illness often face questions of legal competency resulting in protracted jail stays and hospitalization to resolve the issue. It is common for them to languish in jail ten times longer than comparably-charged individuals without a mental illness.

5. Total Dollars Available

For the specific investment strategy #2.1, "Partnering in initiatives to identify, engage and house long-term homeless people," the following funds are available.

	2007	**Annually 2008-2011**
Veteran's Levy	$141,000	$246,000
Human Services Levy	$329,000	$574,000
Total	**$470,000**	**$820,000**

These funds are to be divided between the South King County initiative, this procurement plan to develop and manage a database of high utilizers, and an outreach and engagement initiative still under development. Thirty percent of the funding for this initiative is from the Veteran's Levy and 70 percent is from the Human Services Levy.

- The South King County procurement plan has received $144,000 of the total funds available for 2007 and projects utilization of $370,000 per year in 2008-2011.
- This procurement plan requests $238,000 of the remaining 2007 funds (to be utilized in 2008) and projects the need for maintenance level funding of $120,000 per year in 2009-2011. Please refer to Section 8 for more detail.

For the specific investment strategy #5.7, "Consultation and training related to protocols and policies for release of information and sharing of patient information," $150,000 in one time only funds is available. This procurement plan requests $150,000 of those funds. Fifty percent of the funding for this strategy is from the Veteran's Levy and 50 percent is from the Human Services Levy.

6. Geographic Coverage

The database will be comprised of the minimum necessary information about individuals from the target population who reside anywhere in King County. They will be eligible to be linked to suitable housing programs, services and supports throughout the region.

7. Evidence-Based or Best Practice Information

Identification and tracking of individuals from the target population will facilitate referrals to several existing and developing evidence-based or best practice models of housing and service provision. The following represent some of those evidence-based or best practice models in King County:

- Program for Assertive Community Treatment (PACT)
- Forensic Assertive Community Treatment (FACT)
- DESC 1811 Housing First program
- City of Seattle Housing First (several sites)
- High Fidelity Supported Employment
- Clubhouses (Hero House, Wallingford House)
- King County Care Partners
- GAU Mental Health Pilot
- Outreach and engagement programs for homeless individuals (HOST, PATH, REACH, etc.)

8. Program Description

Levy funds are proposed to be used to develop and maintain a centralized high utilizer database, housed within the DCHS Mental Health Chemical Abuse and Dependency Services Division (MHCADS). The database will collect the minimum necessary information regarding chronically homeless individuals who might benefit from referral to appropriate housing, treatment and supports. Contingent upon data sharing and/or business associate agreements, information may be drawn from several existing databases, including but not limited to the mental health, substance abuse, Safe Harbors, Veteran's Administration, state hospital, community hospital and King County Jail information systems. Core data elements will include:

- Demographic information
- Hospital admissions
- Emergency room visits
- Use of sobering or detox services
- Use of shelters
- Incarcerations
- Use of mental health and/or substance abuse treatment services
- Housing status
- Veteran's status
- Eligibility for public funding
- Race, ethnicity and primary language
- Chronic health needs (i.e., diabetes, heart disease)

The database will be a resource to any publicly funded housing program that provides services to the target population. Information will be retrievable only after a prospective client has given permission to release it to a specific program or programs. The following is an example of how the database will benefit these individuals:

Information about the target population will be continuously updated by MHCADS. If there is an opening in an intensive supportive housing program such as PACT, the PACT program will be able to request real time pertinent information about potential PACT participants (after obtaining permission from the individuals). The PACT program will be able to explore whether an individual is eligible for their program and/or whether they are being engaged by other programs. This will promote rapid, targeted outreach and engagement, including linkage to suitable housing resources.

MHCADS will draw upon the expertise and knowledge of acknowledged experts in the field to ensure that the database and ultimately the coordinated entry model satisfy relevant privacy, security and confidentiality requirements. Another goal of outside consultation will be to determine the feasibility of incorporating elements of best practice models from other locales (i.e., Washtenaw County Michigan, Whatcom County, Washington). The result will be a state-of-the-art, dynamic and responsive shared information hub that will facilitate systematic, coordinated outreach and referrals.

Levy funds will be utilized to support the additional staff resource needed to develop and maintain the database and link to the planned coordinated outreach and referral system.

Project Manager III (Temporary fulltime MHCADS position for four years, from 2008-2011)

Duties and Responsibilities: Project lead. Develop and implement business processes, policies and procedures, memoranda of understanding, standardized releases of information and consent agreements, data sharing and business associate agreements. Coordinate consultant activities and integrate consultant recommendations in the development of the system. Coordinate system wide training and consultation related to information sharing regulations and protocols. Coordinate with coalition partners and other stakeholders in the development of a coordinated outreach and referral system.

Information Technology Senior Application Developer (Temporary fulltime MHCADS position for one year)

Duties and Responsibilities: Work in collaboration with project lead. Design and develop high utilizer database, including identification of minimum data set, developing relational tables, indexes and stored procedures. Design and develop matching processes, user interfaces, and standard reports. Define and develop processes for getting data from each source. Develop documentation for users of the database and application.

	Annual Salary, Benefits & Indirect Costs (2008 rates)
Lead Project Manager	$ 96,000
Senior Application Developer	$105,000
Indirect costs	$ 37,000
Total	**$238,000**

Consultant Services

Scope of Work: Advise MHCADS and other stakeholders during the developmental phase of the high utilizer database and linked outreach and referral system. Assist project lead in assuring compliance with statutory and regulatory requirements. Conduct in-depth analysis of promising models for shared information systems in other locales and make recommendations regarding applicability to this and associated future projects. Provide training and consultation to stakeholders involved in the development and implementation of the database and coordinated care system.

	Costs
Administrative costs associated with the RFP process, support by MHCADS staff and county legal counsel	$100,000
~100 hours of consultation	$250-$400/hour
~75 hours of training	$125/hour
Total	**$150,000**

Total Funds requested for 2007-8 (Phase 2)

	Total Available	**Funds Requested**
Strategy #2.1	$326,000	$238,000
Strategy #5.7	$150,000	$150,000
Total	**$476,000**	**$388,000**

Total Funds requested for 2009-2011 (Phase 3)

	Total Available Annually	**Funds Requested For 2009-2011**
Strategy #2.1	**$450,000**	**$120,000/year**

9. Disproportionality Reduction Strategy

Racial inequities are clearly demonstrated within the chronically homeless population. According to the 2007 One Night Count report, 57 percent of those identified as homeless are people of color. (People of color comprise 27 percent of the general population in King County.)

The high utilizer database will help identify chronically homeless individuals who are repeat users of emergency services, jails and hospitals and who are disproportionately represented in such settings. The database will include racial and other demographic information. This systematic data collection will promote the creation of targeted interventions designed to reduce barriers to accessing and maintaining permanent housing.

10. Coordination/Partnerships

The development of a "high-utilizer" database is a joint goal of many regional partners, including:

- King County Department of Community and Human Services, Directors' Office and Mental Health, Chemical Abuse and Dependency Services Division
- Public Health of Seattle/King County, Jail Health Services
- Public Health of Seattle/King County, HealthCare for the Homeless
- Committee to End Homelessness
- King County Department of Adult and Juvenile Detention
- City of Seattle, Human Services Division and Office of Housing
- King County Housing Authority
- Seattle Housing Authority
- United Way of King County
- Safe Harbors Homeless Management Information System (HMIS)[1]
- Seattle Municipal Court
- District Courts
- Harborview Medical Center
- Washington State Department of Social and Health Services, Aging and Disabilities Administration, Region IV, Home and Community Services Division

In addition to local partnerships, development and maintenance of the database will require coordination with other agencies in order to share data, which at a minimum may include the following:

- Washington State Department of Social and Health Services
    - Health and Recovery Services Administration's Division of Mental Health, Division of Alcohol and Substance Abuse, and Western State Hospital
    - Research and Data Analysis (RDA)
- Department of Health, Community Hospital Abstract Reporting System (CHARS)
- Other hospital emergency departments in King County

11. Timeline

Phase 1: MHCADS staff participated in preliminary planning and evaluation of models for development of a more comprehensive high utilizer database throughout 2007. Related activities included:

- DCHS/MHCADS sponsored stakeholder meetings – March and April 2007 – Evaluated models for developing the database and a coordinated referral system
- DCHS/MHCADS internal planning and development – March 2007 and ongoing – Evaluated models for developing the database and developed preliminary work plan

[1] The High Utilizer Database is distinct from the Safe Harbors HMIS in that it will integrate information from multiple existing databases and will focus on those chronically homeless who make frequent use of costly emergency services and supports. MHCADS will coordinate closely with the City of Seattle/Safe Harbors HMIS to avoid duplicative efforts.

- Development and refinement of data sharing agreements – January 2007 and ongoing – Agreements facilitated data sharing for Criminal Justice Initiatives, Housing First projects and REACH
- Development and implementation of discrete 'high utilizer referral lists' for PACT, FACT and Housing First programs – January 2007 and ongoing
- United Way Health and Chemical Dependency Impact Council, Cross System Work Group – January 2007 and ongoing – Coalition supported by consultant developed long term strategic framework to address needs of the safety net population
- United Way Partnership to End Homelessness – June 2007 and ongoing – Five major partners (United Way of King County, City of Seattle, King County, Seattle Housing Authority and King County Housing Authority) developed "Blueprint to End Chronic Homelessness in King County
- United Way Shared Information Community Forum – October 2007 – Overview of current models for sharing healthcare information and coordinating care in Michigan, Whatcom County and other sites nationwide. Forum organized by Impact Council, Cross System Work Group

Phase 2: Development and implementation of a high utilizer database with funding from the Veteran's and Human Services Levy

- Procurement Plan reviewed and approved – March 2008
- Recruitment and hiring of Project Manager and Senior Application Developer (Two fulltime, temporary MHCADS employees) – March-April 2008
- Development and release of RFP for consultant services – May 2008
- Award to successful RFP bidder, contract negotiation and execution – June-July 2008
- Implementation of work plan – Ongoing from January 2008 with expected completion December 2008-January 2009

Phase 3: Database maintenance and linkage with high utilizer care coordination system.

- Ongoing database maintenance and linkage (supported by full-time MHCADS Project Manager) – January 2009-December 2011

12. Funding/Resource Leverage

The development of a high utilizer database and linked outreach and referral systems represents a partnership of philanthropy, housing authorities and public funders that models cross-system policy-making, funding and collaborative implementation. Current and expected commitments will maximize resources from:

- Public Health Seattle/King County
- King County Department of Community and Human Services
- City of Seattle
- United Way of King County
- Committee to End Homelessness
- King County Human Services Coalition

- King County Veterans and Human Service Levy
- Washington State Department of Social and Health Services/Health and Recovery Services Administration/Mental Health Division
- Washington State Department of Social and Health Services/Health and Recovery Services Administration/Division of Alcohol and Substance Abuse
- Washington State Department of Community Trade and Economic Development

13. Outcomes

See Section 19.

14. Dismantling Systemic/Structural Racism Strategy

Throughout the development and implementation of the high utilizer database and coordinated entry system, DCHS/MHCADS will work closely with system partners to identify, through process evaluations and other performance measurement, the structures, barriers and/or deficits in the justice and treatment systems in order to address those that perpetuate racism and the disparate representation of and outcomes for individuals served. If disparate outcomes persist, MHCADS and other stakeholders will be able to utilize the database to support thorough analyses of barriers and to promote timely modifications in programs and/or approaches.

King County MHCADS staff participated in training related to undoing institutional racism with a specific emphasis on the processes employed to procure and contract with community based agencies that provide treatment services for consumers. The tools and strategies identified in those trainings will be utilized to support current and future practices related to this project.

As previously noted, the database will contain information about race, ethnicity and primary language, which can be compared with service utilization information to help identify trends, and inform policy development and planning.

15. Cultural Competency

All DCHS staff attended a training to improve cultural competency. In addition, select staff attended additional training relevant to culturally competent contracting and monitoring. DCHS and its divisions and programs are concerned about cultural competency and will be holding intensive sessions with staff regarding cultural competency in RFP processes and contract development this spring. All RFP's will include questions about cultural competency and how the ethnic and cultural make-up of clients is to be addressed in agency planning, evaluation and service provision.

16. Alignment within and across systems

Development of a high utilizer database will further promote coordination and integration of regional efforts to address the needs of homeless individuals who make the highest use of public safety and emergency medical and treatment systems. Key partners will be involved as the database is developed and implemented to ensure that it aligns dynamically with the goals and strategies of existing coalitions and initiatives (See Section 10 for key partners).

17. Improvement in Access to Services

Development of a high utilizer database linked to an outreach and referral system will by definition result in 'improvement in access to services.' It is more likely that individuals will be identified and referred in a timely manner to effective services, which will reduce utilization of costly resources and increase the likelihood of improved housing stability and individual functioning.

18. Provider Selection/Contracting Process

For strategy 2.1, DCHS/MHCADS staff will be responsible for developing and maintaining the high utilizer database. The preliminary stakeholder work and modeling determined that MHCADS was the central entity most appropriate to serve as the database management site. Once the database is operational, it is expected that the coordinated outreach and referral functions will be managed by an entity other than MHCADS.

For strategy 5.7, DCHS/MHCADS will conduct a competitive RFP process to select a consultant or consultants to assist with system-wide development and training related to protocols and policies for release and sharing of personal health information.

19. Process and Outcome Evaluation

The investment strategy to identify, engage and house chronically homeless high utilizers will be evaluated through measurement of processes and outcomes. MHCADS will coordinate with the DCHS, Community Services Division levy evaluation section to measure the effect of the Levy on processes such as timely and appropriate referrals, collaboration and other system level changes. Typical outcomes of outreach and engagement programs are increased housing stability, enrollment in treatment and primary care, and increased income (including veterans' benefits and state entitlements). These outcomes are in alignment with the overall goals of the Levy. In addition, the following outcomes will be measured and tracked for those individuals identified through the high utilizer database. All outcomes will be tracked by race and ethnicity in addition to other demographic and program-specific factors.

Reduction in:

- community and state psychiatric hospital admissions and days
- jail bookings and days incarcerated
- acute medical/ER services
- acute substance use/detoxification services
- homeless episodes

Increase in:

- days housed in the community
- mental illness symptom improvement